

Substance Abuse Treatment: Addressing the Specific Needs of Women

A Treatment Improvement Protocol TIP 51



Substance Abuse and Mental Health Services Administration

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A Treatment Improvement Protocol

TIP 51

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at <http://store.samhsa.gov>.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey “front-line” information quickly but responsibly. If research supports a particular approach, citations are provided.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills the Substance Abuse and Mental Health Services Administration's (SAMHSA's) mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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3 Physiological Effects of Alcohol, Drugs, and Tobacco on Women

In This Chapter

Physiological Effects and Consequences of Substance Abuse in Women

Physiological Effects: Factors of Influence

Physiological Effects of Alcohol

Physiological Effects of Licit and Illicit Drugs

Physiological Effects of Tobacco Use

Effects of Alcohol, Drugs, and Tobacco on Pregnancy and Birth Outcomes

Effects of Alcohol and Illicit Drugs on HIV/AIDS Status

Overview

Based on human and animal studies, women are more sensitive to the consumption and long-term effects of alcohol and drugs than men. From absorption to metabolic processes, women display more difficulty in physically managing the consequences of use. In general, with higher levels of alcohol and drugs in the system for longer periods of time, women are also more susceptible to alcohol- and drug-related diseases and organ damage.

This chapter provides an overview of the physiological impact of alcohol and drugs on women, with particular emphasis on the significant physiological differences and consequences of substance use in women. It begins with a general exploration of how gender differences affect the way alcohol and drugs are metabolized in the body and then highlights several biopsychosocial and cultural factors that can influence health issues associated with drugs and alcohol. The chapter goes on to explore the physiological effects of alcohol, drugs (both licit and illicit), and tobacco on the female body. A summary of key research on the impact of these substances when taken during pregnancy follows, and the chapter closes with a review of the effect that substance abuse has on women's HIV/AIDS status. Counselors can use the information presented in this chapter to educate their female clients about the negative effects substances can have on their physical health. A sample patient lecture is included that highlights the physiological effects of heavy alcohol use.

Physiological Effects and Consequences of Substance Abuse in Women

Alcohol and drugs can take a heavy toll on the human body. The same general statements can be made for both men and women about their long-term effects—for example, both genders incur liver problems resulting from alcohol abuse, respiratory impairment and lung cancer as a consequence of smoking, HIV/AIDS and hepatitis from injection drug use, and memory difficulties associated with the use of marijuana. Yet women have different physical responses to substances and greater susceptibility to health-related issues. Women differ from men in the severity of the problems that develop from use of alcohol and drugs and in the amount of time between initial use and the development of physiological problems (Greenfield 1996; Mucha et al. 2006). For example, a consequence of excessive alcohol use is liver damage (such as cirrhosis) that often begins earlier in women consuming less alcohol over a shorter period of time. By and large, women who have substance use disorders have poorer quality of life than men on health-related issues.

In addition, women who abuse substances have physiological consequences, health issues, and medical needs related to gynecology (Peters et al. 2003). Specifically, drugs and alcohol affect women's menstrual cycles, causing increased cramping and heavier or lighter periods. Women sometimes use illicit drugs and alcohol as medication for cramping, body aches, and other discomforts associated with menstruation (Stevens and Estrada 1999). On the other hand, women who use heroin and methadone can experience amenorrhea (absence of menstrual periods; Abs et al. 2000), leading them to believe that they are unable to conceive and misreading early signs of pregnancy as withdrawal symptoms. Subsequently, they are unaware that they are pregnant. Women's substance use also poses risks to fetuses and nursing infants.

Limitations of Current Research on Gender Differences in Metabolism

In general, research on the unique physiological effects of alcohol and drugs in women is limited and sometimes inconclusive. Although the differences in the way women and men metabolize alcohol have been studied in some depth, research on differences in metabolism of illicit drugs is limited. For many years, much of the research on metabolism of substances either used male subjects exclusively or did not report on gender differences. Historically, women were omitted due to the potential risk of pregnancy and the possibility that hormonal changes across the menstrual cycle would wreak havoc on the drugs' effects and subsequent results.

Available research is typically based on small sample sizes and has not been replicated. Race and ethnic background can affect metabolism and the psychological effects of alcohol and illicit drugs, as can the psychopharmaceuticals sometimes used in treatment (Rouse et al. 1995), but their effects have not been studied. Similar to men, few women abuse only one substance. Polysubstance use complicates the ability to study and understand the physiological effects of specific drugs on women, while increasing the risk associated with synergistic effects when substances are combined. Significant gaps in knowledge exist regarding physiological effects across the continuum of a woman's life.

Physiological Effects: Factors of Influence

Ethnicity and Culture

The level of acculturation and cultural roles and expectations play a significant role in substance use patterns among women of color (Caetano et al. 2008). The prevalence of substance abuse among ethnic women typically coincides with higher levels of acculturation in the United States, thus leading to greater health issues. Literature suggests that women from ethnically diverse backgrounds who have substance use

disorders possess greater risks for developing certain conditions and disorders, such as hypertension, high blood pressure, and HIV/AIDS (Centers for Disease Control [CDC] 2000a, b; Steffens et al. 2006; Vernon 2007). These health disparities arise from many sources, including difficulty in accessing affordable health care, delays in seeking treatment, limited socioeconomic resources, racism, and discrimination (Gee 2002; Mays et al. 2007; Williams 2002). In addition, mistrust of health care providers is a significant barrier to receiving appropriate screening, preventive care, timely interventions, and adequate treatment (Alegria et al. 2002). More recent studies have explored the role of gender in perceived discrimination and health, and some studies have noted differences in the type of stressors, reactions, and health consequences between men and women (Finch et al. 2000; Flores et al. 2008). For example, the Black Women's Health Study found that perceived experiences of racism were associated with an increased incidence of breast cancer (Taylor et al. 2007).

Sexual Orientation

Lesbian/bisexual women exhibit more prevalent use of alcohol, marijuana, prescription drugs, and tobacco than heterosexual women, and they are likely to consume alcohol more frequently and in greater amounts (Case et al. 2004; Cochran et al. 2001, 2004). Based on the Substance Abuse and Mental Health Services Administration's (SAMHSA's) 1996 National Household Survey on Drug Abuse, researchers compared patterns of use between homosexual and heterosexual women and found that lesbians have greater alcohol-related morbidity (Cochran et al. 2001). Likewise, they are less likely to have health insurance and to use preventive screenings, including mammograms and pelvic examinations. With less utilization of routine screenings, lesbians and bisexual women may not be afforded the benefit of early detection across disorders, including substance use disorders, breast cancer, and cardiovascular disease.

Socioeconomic Status and Homelessness

Overall, lower socioeconomic status is associated with higher mortality rates and greater risks for cervical cancer, coronary heart disease, HIV/AIDS, and other health conditions and medical disorders (Adler and Coriell 1997). More than ethnicity, socioeconomic status heavily influences the health risks associated with substance abuse. Research suggests that when the socioeconomic conditions of ethnically diverse populations are similar to those of the White population, consequences of substance use appear comparable (Jones-Webb et al. 1995). Among women, alcohol and drug-related morbidity and mortality are disproportionately higher in individuals of lower socioeconomic status, which is associated with insufficient healthcare services, difficulties in accessing treatment, lack of appropriate nutrition, and inadequate prenatal care. Subsequently, impoverished women who abuse substances often experience greater health consequences and poorer health outcomes.

Similarly, homelessness is associated with higher mortality rates for all life-threatening disorders, including greater risks for infectious diseases. With greater high-risk sexual behaviors and repeated exposure to overcrowded shelters, homeless women who use injection drugs are more likely to be infected with HIV/AIDS and other infectious diseases, including airborne infections such as tuberculosis, thereby leading to greater health consequences (for review, see Galea and Vlahov 2002).

Developmental Issues and Aging

Although little is known regarding the effect of alcohol and drugs on development across the lifespan, there is some evidence in alcohol-related research that there are different vulnerabilities at different ages for women. Even though developmental research on alcohol is not easily transferred to other drugs of abuse, it can give us a glimpse of the potential physiological issues associated with age and aging. For example, adolescent women are more likely than their male counterparts to experience cognitive impairment

despite less alcohol consumption. Women of child-bearing age are more likely to experience infertility with heavier drinking (Tolstrup et al. 2003). Postmenopausal women are more likely to exhibit significant hormonal changes with heavy consumption of alcohol, leading to potentially higher risks for breast cancer, osteoporosis, and coronary heart disease (Weiderpass et al. 2001). Older women are more sensitive to alcohol and display a decrease in tolerance and alcohol metabolism (Center for Substance Abuse Treatment [CSAT] 1998*d*). While research has been more devoted to examining gender differences, limited data are available for other substances and less is known regarding the effect of these substances on development and aging.

Co-Occurring Disorders: A Bidirectional Influence

According to SAMHSA's National Survey on Drug Use and Health (NSDUH) report (Office of Applied Studies [OAS] 2004*b*), women with co-occurring mental and substance use disorders are likely to experience serious physical health problems. Co-occurring disorders have a bidirectional relationship and often a synergistic effect on one another. As much as substance abuse can increase the risk of, exacerbate, or cause medical conditions, medical disorders can also increase substance abuse as a means of self-medicating symptoms or mental distress associated with the disorder. Similar to men, women who have mental disorders can have more difficulty adhering to health-related treatment recommendations, such as treatment attendance, diet restrictions, or medication compliance.

Physiological Effects of Alcohol

Gender Differences in Metabolism and Effects

Alcohol is a leading cause of mortality and disability worldwide. According to the World Health Organization, alcohol is one of the five

most significant risk factors for diseases, with more than 60 percent of alcohol-related diseases being chronic conditions, including cancer, cirrhosis of the liver, diabetes, and cardiovascular disease (Chisholm et al. 2004).

Alcohol's effects on women have been studied more than those of illicit drugs. Compared with men, women become more cognitively impaired by alcohol and are more susceptible to alcohol-related organ damage. Women develop damage at lower levels of consumption over a shorter period of time (for review, see Antai-Otong 2006). When men and women of the same weight consume equal amounts of alcohol, women have higher blood alcohol concentrations. Women have proportionately more body fat and a lower volume of body water compared with men of similar weight (Romach and Sellers 1998). As a result, women have a higher concentration of alcohol because there is less volume of water to dilute it.

In comparison with men, women, at least those younger than 50, have a lower first-pass metabolism of alcohol in the stomach and upper small intestine before it enters the bloodstream and reaches other body organs, including the liver. One researcher concluded that women's lack of a functional gastric protective barrier means that "for an alcoholic woman to drink alcohol is the same as taking the alcohol directly into a vein," contributing to her greater vulnerability to alcohol-related organ damage (Lieber 2000, p. 417).

These factors may be responsible for the increased severity, greater number, and faster rate of development of complications that women experience from alcohol abuse when compared with men, according to reviews of several studies (Blum et al. 1998; Greenfield 1996). Women develop alcohol abuse and dependence in less time than do men, a phenomenon known as telescoping (Piazza et al. 1989). At a rate of consumption of two to three standard drinks per day, women have a higher mortality rate than men who drink the same amount. Men do not experience an increased mortality risk until they consume four drinks daily (Holman et al. 1996).

Women develop other alcohol-related diseases at a lower total lifetime exposure than men, including such disorders as fatty liver, hypertension, obesity, anemia, malnutrition, gastrointestinal hemorrhage, and ulcers that require surgery (Van Thiel et al. 1989). Heavy alcohol use also increases the risk of hemorrhagic stroke, according to one study cited by Nanchahal and colleagues (2000). Older women respond to alcohol somewhat differently than do younger women. They have even less body water, a heightened sensitivity to and decreased tolerance for alcohol, and a decrease in alcohol metabolism in the gastrointestinal tract (CSAT 1998d).

The following sections identify specific physiological effects related to alcohol use by women. These effects are not distinct from one another; rather, they interact in a synergistic way in the body.

Liver and Other Organ Damage

Females are more likely than their male counterparts to experience greater organ damage as a result of consuming similar amounts of alcohol. Compared with men, women develop alcohol-induced liver disease over a shorter period of time and after consuming less alcohol (Cavaler and Arria 1995). Women are more likely than men to develop alcoholic hepatitis and to die from cirrhosis (Hall 1995). One researcher has theorized that women's faster alcohol elimination rate can endanger the liver by subjecting it to high, though transient, levels of acetaldehyde, a toxic byproduct of alcohol metabolism. This exposure may explain the higher liver cirrhosis rates among women (e.g., Thomasson 2000).

Cardiac-Related Conditions

According to current studies, women who drink exhibit a greater propensity to develop alcohol-induced cardiac damage. While light consumption (less than one drink per day) can serve as a protective factor for women who have a risk for coronary artery disease, studies suggest that protection is not evident for younger women, women who drink heavily, and women without risk factors associated with heart disease. Women

who are dependent on alcohol or consume heavier amounts are more likely to die prematurely from cardiac-related conditions (Bradley et al. 1998a; Fernandez-Sola and Nicolas-Arfelis 2002; Hanna et al. 1992).

Heavy consumption (more than four drinks per day) is associated with increased blood pressure in both women and men (Bradley et al. 1998a). A major epidemiological study found that women between ages 30 and 64 who consumed 15–21 units of alcohol per week had an increased risk of hypertension compared with those who drank 14 or fewer units; those who drank 1–7 units per week had an overall decrease in 10-year risk of cardiovascular disease compared with those who drank more (Nanchahal et al. 2000). The female heart appears to experience a functional decline at a lower level of lifetime exposure to alcohol than does the male heart (Urbano-Marquez et al. 1995).

What constitutes light, moderate, or heavy drinking?

The U.S. Department of Health and Human Services and U.S. Department of Agriculture's definition of moderate alcohol consumption (2005) varies by gender: In women, moderate drinking is considered to be no more than one drink per day, compared with no more than two drinks per day for men. These differences stem from gender differences in body composition and metabolism.

Reproductive Consequences

Research into the adverse impact of alcohol consumption on fertility is growing. While numerous studies have shown a consistent relationship between heavy drinking and infertility (Eggert et al. 2004; Tolstrup et al. 2003), additional studies examining moderate consumption are more inconsistent. Nevertheless, findings suggest a need to educate and screen women for alcohol use while they are seeking infertility treatment (Chang et al. 2006). In addition, heavy drinking is associated with painful and/or irregular menstruation (Bradley et al. 1998a). The repro-

ductive consequences associated with alcohol use disorders range from increased risk for miscarriage to impaired fetal growth and development (Mello et al. 1993).

There are considerable variations among women in their capacity to consume and metabolize alcohol. Early literature suggests that variations in alcohol metabolism among women may be linked to the different phases of the menstrual cycle, but more recent reviews suggest that there are no consistent effects of the menstrual cycle on the subjective experience of alcohol intake or alcohol metabolism (Turner and de Wit 2006). Studies reviewed by Romach and Sellers (1998) found that significant hormonal changes are reported in postmenopausal women who consume alcohol. Women taking hormone replacement therapy (HRT), now referred to as menopausal hormone therapy, and consuming 14 or more standard drinks weekly had significantly higher estradiol levels. These high levels are associated with a greater risk of breast cancer and coronary heart disease.

Breast and Other Cancers

Numerous studies have documented associations and suggested causal relationships between alcohol consumption and breast cancer risk (Key et al. 2006; Li et al. 2003; Zhang et al. 2007). A review of data from more than 50 epidemiological studies from around the world revealed that for each drink of alcohol consumed daily, women increased their risk of breast cancer by 7 percent (Hamajima et al. 2002). Postmenopausal women have an increased risk of breast cancer as well if they currently drink alcohol (Lenz et al. 2002; Onland-Moret et al. 2005). Women who drink alcohol have elevated estrogen and androgen levels, which are hypothesized to be contributors to the development of breast cancer in this population (Singletary and Gapstur 2001). In addition, postmenopausal women who are moderate alcohol drinkers (one to two drinks a day) and who are using menopausal hormone therapy have an increased risk of breast cancer, with even greater risk at higher rates of alcohol consumption (Dorgan et al. 2001; Onland-Moret

et al. 2005).

While the risk for in situ and invasive cervical cancer and cancer of the vagina may be associated with other environmental factors including high-risk sexual behavior, human papilloma viruses, smoking, hormonal therapy, and dietary deficiency, Weiderpass and colleagues (2001) concluded, based on 30 years of retrospective data, that women who are alcohol dependent are at a higher risk for developing these cancers. Similarly, Bagnardi et al. (2001) conducted a meta-analysis of more than 200 studies whereby they found that alcohol significantly increased the risks for cancers of the oral cavity, pharynx, esophagus, larynx, stomach, colon, rectum, liver, and ovaries. Although further investigation is needed to explore the role of alcohol consumption on gastric cancer, preliminary findings suggest that the type of alcoholic beverage, namely medium-strength beer, creates an increased risk of gastric cancer (Larsson et al. 2007). Based on a multiethnic cohort study, the risk of endometrial cancer increases when postmenopausal women consume an average of two or more drinks per day (Setiawan et al. 2008). Additional risks are associated with tobacco use, particularly for cancers of the upper digestive and respiratory tract.

Osteoporosis

According to Bradley and colleagues (1998a), evidence suggests “decreased bone formation and abnormal vitamin D metabolism may predispose alcohol-dependent premenopausal women to osteoporosis” (p. 631). Heavy alcohol use clearly has been shown to harm bones and to increase the risk of osteoporosis by decreasing bone density. These effects are especially striking in young women, whose bones are developing, but chronic alcohol use in adulthood also harms bones (Sampson 2002). In addition, animal studies suggest that the damaging effects of early chronic alcohol exposure are not overcome even when alcohol use ceases (Sampson 1998). Tobacco use also may increase the risk of osteoporosis and fractures; people who drink are 75 percent more likely to smoke, and people who

Clinical Activity: Sample Client-Educating Lecture Outline for Counselors Physiological Effects of Alcohol

This 60-minute lecture provides a general outline highlighting the physiological effects of moderate-to-heavy alcohol use. Refer to this TIP chapter for additional information to support your lecture. To increase participation, first ask women in the group to identify medical problems they believe to be related to their alcohol use. The format of this lecture can also be used with illicit and prescription drugs. Many conditions do occur in men, but it is important to emphasize the enhanced risk and the earlier appearance of these diseases and conditions among women. The list of physiological consequences identifies the most common disorders; it is not intended as a comprehensive review.

- I. Rationale: Women's positive response to health education
- II. Objectives:
 - A. To review what constitutes moderate-to-heavy drinking among women
 - B. To describe physiological differences in how alcohol is metabolized in a woman's body
 - C. To explore the long-term consequences of drinking, with emphasis on specific consequences unique to women
- III. Equipment: Using an easel with newspaper print or a board, draw a human body. As you lecture, write in the effects of alcohol on the body to demonstrate how dramatically alcohol affects women. At the end of the lecture, the body should be covered with physiological consequences.
- IV. Definition: In women, moderate drinking is considered to be no more than one drink per day (U.S. Department of Health and Human Services and U.S. Department of Agriculture [2005]).
- V. Alcohol Metabolism and Women:
 - A. Women have higher blood alcohol concentrations after drinking the same amount of alcohol as men.
 - B. Women have more body fat and a lower volume of body water than men of equal weight. Consequently, women are less able to dilute alcohol once it enters the body, and this leads to a higher concentration of alcohol in the bloodstream and organs.
 - C. Women have a lower concentration of gastric dehydrogenase, an enzyme responsible for metabolism. Because alcohol takes longer to metabolize in women, it has more deleterious effects on major organs for a longer period of time. Longer metabolism and less dilution is a potent mixture for women! In addition, women have smaller organs than men, causing greater vulnerability to the long-term effects of alcohol.

Clinical Activity: Sample Client-Educating Lecture Outline for Counselors Physiological Effects of Alcohol (continued)

VI. Long-Term Consequences: Women experience negative physical consequences and complications from alcohol sooner and at lower levels of consumption than men. Evidence suggests that women progress significantly faster in developing dependence, organ damage, and diseases with much lower levels of alcohol consumption. Women are more likely to die many years earlier from alcohol abuse and dependence.

A. Liver and Other Gastrointestinal Disorders

1. Fatty Liver
2. Alcohol Hepatitis
3. Cirrhosis
4. Liver Cancer
5. Ulcers/Gastritis
6. Pancreatitis
7. Diabetes

B. Cardiac-Related Conditions

1. High Blood Pressure (hypertension)
2. Cardiomyopathy
3. Stroke
4. Arrhythmia

C. Nutritional Deficiencies

1. Malnutrition
2. Vitamin and Mineral Deficiencies

D. Reproductive Consequences

1. Fetal Alcohol Spectrum Disorders: Fetal alcohol syndrome, alcohol-related birth defects (ARBD), partial fetal alcohol syndrome (pFAS), and alcohol-related neurodevelopmental disorder (ARND)
2. Low Birth Weight
3. Miscarriage
4. Painful/Irregular Menstruation
5. Underproduction of Hormones

Clinical Activity: Sample Client-Educating Lecture Outline for Counselors Physiological Effects of Alcohol (continued)

E. Breast and Other Cancers

1. Breast Cancer
2. Throat and Mouth Cancer
3. Stomach and Colon Cancer
4. Other Cancers

F. Osteoporosis

G. Cognitive and Other Neurological Effects

1. Brain Shrinkage
2. Peripheral Neuritis/Neuropathy
3. Dementia
4. Korsakoffs/Wernickes
5. Cerebellar Degeneration

H. Infections: Greater Susceptibility and Progression

1. HIV/AIDS
2. Tuberculosis
3. Pneumonia
1. Other Disorders and Conditions

smoke are 86 percent more likely to drink (Shiffman and Balabanis 1995). Women in menopause who enter treatment need bone density assessment, nutritional guidelines, and medication consultations.

Neurological Effects

Starting with adolescence, women appear to be more susceptible to the toxic effects of alcohol or its metabolites on the nervous system and more vulnerable to alcohol-induced brain damage than men (Bradley et al. 1998a; Hommer et al. 1996; Mann et al. 2005; Mumenthaler et al. 1999). Research supports that adult and adoles-

cent women who are alcohol dependent experience greater declines in cognitive and motor function than men despite less alcohol consumption, shorter history of overall use, and shorter duration of alcohol dependence (Acker 1986; Flannery et al. 2007; Sullivan et al. 2002).

In comparison with men who are alcohol dependent and female controls (women who are not dependent on alcohol), women who are alcohol dependent exhibit deterioration in planning, visuospatial ability, working memory, and psychomotor speed. They also show brain abnormalities and shrinkage after a shorter drinking history and lower peak consumption than

do men. Studies demonstrate that in general, women with alcohol dependence disorders have significantly smaller volumes of gray and white matter, less hippocampal volume (memory), and greater peripheral neuropathy than either men who abused alcohol or women who did not abuse alcohol (Ammendola et al. 2000; Hommer et al. 2001; Romach and Sellers 1998; Schweinsburg et al. 2003).

Women appear to be at greater risk than men for Alzheimer's disease, although women's longer life spans may contribute to this higher risk (Sohrabji 2002). Heavy alcohol consumption is known to result in memory deficits and may increase the risk for Alzheimer's disease in both genders, but particularly in women, who appear to be more vulnerable than men to alcohol-induced brain damage (Sohrabji 2002).

Physiological Effects of Licit and Illicit Drugs

Gender Differences in Metabolism and Effects

Research (Hernandez-Avila et al. 2004) supports the concept of an accelerated progression to treatment entry among women dependent on opioids, cannabis, or alcohol, and suggests the existence of a gender-based vulnerability to the adverse consequences of these disorders. No gender difference was noted for age at onset of regular use, but the women had used opioids, cannabis, and alcohol for fewer years before entering treatment. The severity of drug and alcohol dependence did not differ by gender, but women reported more severe psychiatric, medical, and employment complications than did men. In one substance abuse treatment study focused on urban outpatient clinics, women had more symptoms than men across substances (Patkar et al. 1999). They reported more cardiovascular, mood, nose and throat, neurological, skin, and gastrointestinal symptoms than did men. In addition, there is evidence that women who use injection drugs are more susceptible to medical disorders and conditions (Zolopa et al. 1994). Similarly, women who

use cocaine, heroin, or injection drugs have a heightened risk of developing herpes, pulmonary tuberculosis, and/or recurrent pneumonia (Thorpe et al. 2004).

To date, little is known regarding the consequences of specific drug use among women. Complicated by polysubstance use, studies are often unable to obtain adequate sample sizes of women who abuse only one drug. The following section highlights specific physiological effects of licit and illicit drugs that are unique to women. This is not a general primer on drugs, but rather a compendium of known physiological effects that are gender-specific.

Cocaine, Amphetamine, and Methamphetamine

Hormonal changes across the menstrual cycle have the greatest effect on stimulant drugs, particularly cocaine and amphetamine. Literature highlights a consistent and greater mood-altering effect of stimulant use during the follicular phase of the cycle (for review, see Turner and de Wit 2006), and the fluctuations in progesterone levels may account, in part, for this sex difference (Evans 2007; Evans and Foltin 2006). More specifically, Evans and colleagues (2002) investigated whether cocaine effects vary as a function of menstrual cycle phase; they found that heart rate and ratings such as "good drug effect" were increased more during the follicular phase than the luteal phase. Conversely, injection drugs and/or crack cocaine appear to produce changes in the menstrual cycle, including the development of amenorrhea, degree of blood flow, and the intensity of cramps (Stevens and Estrada 1999). Overall, women who use cocaine report more positive subjective drug effects, including greater euphoria and desire to use, while physiological responses to the drug did not change (McCance-Katz et al. 2005).

Methamphetamine use has an array of possible adverse effects (for review, see Winslow et al. 2007), but data regarding specific gender differences are limited. Psychoactive effects of methylenedioxy-methamphetamine (ecstasy) have been found to be more intense in women than in

men; women report experiencing a higher degree of perceptual changes, thought disturbances, and fear of the loss of control of their bodies. Acute adverse effects, such as jaw clenching, dry mouth, and lack or loss of appetite, are more common among women (Liechti et al. 2001).

Heroin and Other Opioids

Research is lacking that would allow definitive conclusions about gender similarities or differences in the following effects of heroin use: scarred and collapsed veins, bacterial infections of blood vessels and heart valves, abscesses, cellulitis, and liver or kidney disease (National Institute on Drug Abuse [NIDA] 2000).

Research suggests that there are no menstrual cycle differences in women's subjective experience or physiological reaction to opioids (Gear et al. 1996), but women using heroin or methadone do experience menstrual abnormalities, particularly amenorrhea or an irregular menstrual cycle (Abs et al. 2000; Santen et al. 1975; Smith et al. 1982). It can take up to a year for regular menstrual cycles to resume after drug use is stopped. Deficits in sexual desire and performance are also consequences of heroin use (Smith et al. 1982). These symptoms probably are related to the lower levels of luteinizing hormone, estradiol, and progesterone found in these women (Abs et al. 2000). Amenorrhea and other symptoms often make women believe they are permanently sterile, a fear that can be lessened with education. *TIP 43 Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (CSAT 2005b) provides more information.

Marijuana

Studies on marijuana effects have not focused specifically on gender differences; therefore, little is known about how marijuana affects men and women differently. In studies evaluating hormonal changes and the physiological and psychological effects of marijuana use, findings suggest that the effects of marijuana do not vary markedly across the menstrual cycle (Block et al. 1991; Griffin et al. 1986; Lex et al. 1984).

Effects of marijuana on birth outcomes are discussed below.

Prescription and Over-the-Counter Medications

Women are significantly more likely to use and abuse prescription medications, including anxiolytics (anxiety medications) and narcotic analgesics (pain medications), than are men (Simoni-Wastila 2000). Little research is available, however, on the gender differences and differential physiological effects of abuse of prescription medications. Moreover, research into the influence of hormonal changes across the menstrual cycle on subjective, behavioral, and physiological effects is limited to benzodiazepines, and findings are minimal (Bell et al. 2004; Kamimori et al. 2000).

Over-the-counter (OTC) medications include cold remedies, antihistamines, sleep aids, and other legally obtained nonprescription medications. It is not uncommon for individuals with eating disorders, particularly those diagnosed with bulimia nervosa, to abuse laxatives, diuretics, emetics, and diet pills. Misuse of these medications can result in serious medical complications for those with eating disorders, who primarily are women (U.S. Department of Health and Human Services, Office on Women's Health 2000). Complications can involve the gastrointestinal, neuromuscular, and cardiac systems and can be lethal. Many prescription and OTC medications interact negatively with alcohol and drugs.

Gender Differences and OTC Drugs

Across studies, prevalence rates comparing the use and misuse of OTC medications among men and women vary according to age and race/ethnicity. For individuals 65 years of age and older, women are more likely to use OTC drugs (Halon et al. 2001). NSDUH evaluated the misuse of OTC cough and cold medications among persons aged 12 to 25 (SAMHSA 2007) and found that women aged 12 to 17 were more likely than men

to have misused OTC cough and cold medications in the past year, while men between 18 and 25 years of age were more likely to have misused these medications. Whites and Hispanics had higher rates of misuse than African Americans. Similar to men, women who had ever misused OTC cough and cold medications also had lifetime use of marijuana and inhalants. In evaluating prescription and OTC drug treatment admissions, women represented a larger proportion

of prescription and OTC medication admissions (46 percent) than treatment admissions for all substances (30 percent; SAMHSA 2004).

“Every woman is different. No amount of drinking is 100 percent safe, 100 percent of the time, for every individual woman” (National Institute on Alcohol Abuse and Alcoholism [NIAAA] 2003).

Physiological Effects of Tobacco Use

The health risks associated with nicotine use are considerable, particularly among women. In comparison with men, women who smoke show higher disease risk regardless of smoking level or intensity (Mucha et al. 2006). Currently, cancer is the second leading cause of death among women, with mortality rates higher for lung

cancer than breast cancer. According to the Office of the Surgeon General (2001b), women who smoke:

- Have an increased risk of peptic ulcers and Crohn’s disease.
- Have an increased risk of estrogen deficiency; difficult, irregular or painful menstruation; and amenorrhea.
- Are more likely to be diagnosed with cancer, including cancer of the lung, bladder, cervix, pancreas, kidney, larynx, esophagus, liver, and colon.

- Have a higher risk for delayed conception and infertility.
- Are more likely to deliver premature and low-birth-weight infants.
- Have an increased risk for ischemic stroke, subarachnoid hemorrhage, peripheral vascular atherosclerosis, and an abdominal aortic aneurysm rupture.
- Are more likely to have premature decline in lung function, chronic obstructive pulmonary disease, and coronary heart disease.
- Have an increased risk of developing cataracts and macular degeneration.
- Reach menopause at a younger age.
- Have lower bone densities and an increased risk for hip fracture after menopause.

Effects of Alcohol, Drugs, and Tobacco Use on Pregnancy and Birth Outcomes

The use of alcohol, drugs, and tobacco can affect a pregnant woman in a variety of ways. Substance use can result in obstetric complications, miscarriage, or significant problems for the fetus. It is difficult to tease out individual effects of licit and illicit substances on fetal and infant development because women who abuse these substances typically abuse more than one, and the substance abuse can be accompanied by psychological distress, victimization, and poverty. A detailed discussion of alcohol- and drug-related problems in infants and children is beyond the scope of this TIP except insofar as these problems create additional demands and stressors for women as well as guilt and shame about the use of alcohol, drugs, and/or tobacco during pregnancy. This section highlights specific effects of alcohol and drugs during the course of pregnancy.

Alcohol Use and Birth Outcomes

Above all other drugs, alcohol is the most common teratogen (any agent that interrupts development or causes malformation in an embryo or fetus) in pregnancy (Randall 2001).

In utero, alcohol use is associated with an increased risk of spontaneous abortion and increased rates of prematurity and abruptio placentae (premature separation of the placenta from the uterus). A study found that women who consumed five or more drinks per week were three times as likely to deliver a stillborn baby compared with those who had fewer than one drink per week (Kesmodel et al. 2002).

Maternal alcohol use during pregnancy contributes to a wide range of effects on exposed offspring, known as fetal alcohol spectrum disorders (FASDs), and the most serious consequence is fetal alcohol syndrome (FAS). FAS is characterized by abnormal facial features, growth deficiencies, and central nervous system problems (Jones and Smith 1973). Symptoms can include hyperactivity and attention problems, learning and memory deficits, and problems with social and emotional development. Infants who show only some of these features were previously identified as having fetal alcohol effects (FAE). Since 1996, the term FAE has been replaced by alcohol-related birth defects (ARBD), partial fetal alcohol syndrome (pFAS), and alcohol-related neurodevelopmental disorder (ARND; Stratton et al. 1996). Children with ARBD have problems with major and sensory organs, as well as structural abnormalities; children with ARND have central nervous system abnormalities (Green 2007). Despite alcohol-related birth defects being completely preventable, FASDs are the most common nonhereditary causes of mental retardation (CDC 2002).

Another risk factor associated with alcohol exposure in utero is the potential of substance use disorders. Alati et al (2006) found an association of early-onset of alcohol disorders among children exposed to alcohol prenatally; this association was more pronounced with early pregnancy exposure. While little is known about the prevalence of FASD among individuals with substance use disorders, this co-occurring condition is likely to further challenge recovery effects. For guidelines in identifying and referring persons with FAS, see CDC (2005).

Women who drink during breastfeeding pass

alcohol on to the baby. Although numerous studies of laboratory animals have demonstrated a variety of adverse outcomes in breastfed offspring during periods when their mothers are consuming alcohol, human data are limited. A review of empirical literature on women who drink while breastfeeding provides evidence that maternal alcohol consumption does not promote lactation and may affect infant sleep patterns. (for review, see Giglia and Binns 2006)

Cocaine Use and Birth Outcomes

According to reviews of several studies conducted during the late 1980s and early 1990s, there are a variety of adverse effects of cocaine use during pregnancy (Zuckerman et al. 1995; Burkett et al. 1994). Studies reported that cocaine-exposed infants had smaller head circumference; lower birth weight and length; irritability; poor interactive abilities; and an increased incidence of stillbirth, prematurity, and sudden infant death syndrome (SIDS; Bell and Lau 1995). Other studies dispute many previously reported severe effects of prenatal exposure of cocaine on the offspring. Frank and colleagues' review (2001) of the literature found that the most consistent effects were small size and less-than-optimal motor performance.

Eyler and colleagues (2001) found no evidence of the previously reported devastating effects of prenatal cocaine exposure. Hurt and colleagues

The SAMHSA
FASD's Center for
Excellence Web site
provides information
and resources
about FASD and
related information
on legislation,
treatment and
training curricula,
and community
awareness ([http://
www.fascenter.
samhsa.gov/](http://www.fascenter.samhsa.gov/)).

Advice to Clinicians: **Substance Use and Birth Outcomes**

- Counselors should be sensitive to female clients who are pregnant and help them manage the additional stresses, demands, and guilt that pregnancy can cause in a woman already struggling with a substance use disorder.
- Counselors can take the opportunity to educate their pregnant clients about how alcohol, tobacco, and cocaine affect the fetus in a variety of ways that are dose and timing dependent, which is an optimistic basis for encouraging pregnant women to remain abstinent during pregnancy and while breastfeeding.
- Pregnant women using opioids should enter methadone maintenance treatment, which protects the fetus from repeated episodes of withdrawal, eliminates the risks of infection from needles, and creates a mandatory link to prenatal care.

(1995) followed a cohort of cocaine-exposed infants from birth to age 6; although they found lower weight and head circumference, they found no difference in developmental scores between cocaine-exposed and non-cocaine-exposed infants. However, other evidence suggests that children exposed to cocaine during the first trimester were smaller on all growth parameters at 7 and 10 years of age compared with children who were not exposed to cocaine (Richardson et al. 2007). This longitudinal analysis indicated that the disparity in growth between both groups did not converge over time.

An extensive review by Frank and colleagues (2001) of all studies published in English from 1984 to 2000 (N = 74) that met rigorous methodological criteria (N = 36) concluded that many apparent adverse outcomes of cocaine use during pregnancy “can be explained ... by other factors, including prenatal exposure to tobacco, marijuana, or alcohol and the quality of the child’s environment” (p. 1624). Other studies (Hurt et al. 2001; Kaltenbach 2000; Lewis et al. 2004b; Messinger et al. 2004) have supported this conclusion. Singer et al. (2004) reported that the quality of the caregiving environment was the strongest independent predictor of cognitive outcomes among children exposed to cocaine.

Nonetheless, the effects of cocaine on the fetus may be dose and timing dependent, and significant cocaine use during pregnancy, with or without other drug use, is associated with

negative consequences for the offspring and the mother (Thaithumyanon et al. 2005). Birth weight, length, and head circumference of infants with high exposure to cocaine differed from those with low or no exposure (Bateman and Chiriboga 2000). Heavily cocaine-exposed infants were found to have more jitteriness and attention problems than infants with light or no exposure to cocaine and lower auditory comprehension than unexposed infants (Singer et al. 2000). Evidence suggests that subtle deficits exist in cognitive and attentional processes in cocaine-exposed preschool and 6-year-old children (Leech et al. 1999; Mayes et al. 1998). In addition, infants exposed to cocaine during pregnancy had more infections, including hepatitis and HIV/AIDS exposure (Bauer et al. 2005). Much is still unknown about the effects of prenatal cocaine exposure. However, cocaine use by a pregnant woman should be viewed as an indication of multiple medical and social risk factors (Eyler and Behnke 1999; Tronick and Beeghly 1999); her ability to access prenatal care, gain supportive and effective case management services, and obtain substance abuse treatment can make all the difference in outcome.

Opioid Use and Birth Outcomes

Opioid use in pregnant women presents a difficult situation because of the many medical complications of opioid use, such as infections passed to the fetus by the use of contaminated needles. Obstetric complications in pregnant

Note to Clinicians

Since timely treatment for HIV/AIDS can virtually eliminate the chance of a pregnant woman passing the infection to her fetus, all women with substance use histories should have an HIV/AIDS evaluation at the first sign of any possible pregnancy.

women who use opioids often are compounded by lack of prenatal care. Complications include spontaneous abortion, premature labor and delivery, premature rupture of membranes, preeclampsia (high blood pressure during pregnancy), abruptio placentae, and intrauterine death. The fetus is at risk for morbidity and mortality because of episodes of maternal withdrawal (Kaltenbach et al. 1998).

Reviews of several studies recommend methadone maintenance treatment (MMT) as the only treatment for the management of opioid dependence during pregnancy because, when methadone is provided within a treatment setting that includes comprehensive care, obstetric and fetal complications, including neonatal morbidity and mortality, can be reduced (Jarvis and Schnoll 1995; Kaltenbach et al. 1998). Effective MMT prevents the onset of withdrawal, reduces or eliminates drug craving, and blocks the euphoric effects of illicit self-administered opioids (Dole et al. 1966a, b; Kreek 1988). The use of methadone in pregnancy prevents erratic maternal opioid levels and protects the fetus from repeated episodes of withdrawal. Because needle use is eliminated, MMT reduces the risk of infectious diseases. The mandatory link to prenatal care, frequent contact with program staff, and elimination of the stress of obtaining opioids daily to feel “normal” are additional benefits from MMT (Burns et al. 2006).

Reviews of the literature note that studies consistently have found that fetuses exposed to opioids (i.e., heroin and methadone) have lower birth weights than unexposed fetuses and usually undergo neonatal abstinence syndrome (NAS) at birth. NAS is a generalized disorder characterized by signs and symptoms of central nervous system irritability, gastrointestinal dysfunction, respiratory distress, vomiting, and fever, among other symptoms. NAS can be more

severe and prolonged with methadone exposure than heroin exposure, but with appropriate pharmacotherapy, NAS can be treated effectively (Kaltenbach 1994; Kaltenbach et al. 1998).

Although findings among studies are diverse, most suggest that methadone-exposed infants and children through age 2 function well within the normal range of development and that methadone-exposed children between ages 2 and 5 do not differ in cognitive function from a population that was not drug exposed and was of comparable socioeconomic and racial background (Kaltenbach 1996). Data suggest that such psychosocial factors as environment and parenting can have as much of an effect on development as prenatal exposure to opioids (Johnson et al. 1987; Lifschitz et al. 1985).

In more recent years, buprenorphine treatment has been examined as an alternative to maintenance therapy for opioid dependence during pregnancy. Nonetheless, research is limited and only two randomized, double-blind studies have been conducted comparing methadone with buprenorphine (Fischer et al. 2006; Jones et al. 2005; Kayembe-Kay’s and Lacyde 2003; Raburn and Bogenschultz 2004). For additional information on maintenance therapies during pregnancy, see TIP 43 *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (CSAT 2005a) and TIP 40 *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction* (CSAT 2004a).

Marijuana Use and Birth Outcomes

The limited research on the effects of prenatal exposure to marijuana shows somewhat inconsistent results (Bell and Lau 1995).

Longitudinal studies by Day and colleagues (1992) found marijuana to be associated with reduced length at birth, but it did not affect weight or head circumference. Hurd et al. (2005) found that exposed fetuses had significantly reduced body weight and length, even when the data were adjusted to account for maternal alcohol consumption and smoking. Children prenatally exposed to marijuana functioned above average on the Bayley Scale of Infant Development (BSID) at 9 months, but third-trimester marijuana use was associated with decreased BSID mental scores. Followup assessment of these children at age 10 found that prenatal marijuana exposure was associated with higher levels of behavior problems (Goldschmidt et al. 2000). In a review of existing data, Fried and Smith (2001) reported that although global IQ is unaffected by prenatal marijuana exposure, aspects of executive function appear to be negatively associated with prenatal exposure in children beyond the toddler stage.

Amphetamine and Methamphetamine Use and Birth Outcomes

Exposure to amphetamines in utero has been associated with both short- and long-term effects, including abnormal fetal growth, withdrawal symptoms after birth, and impaired neurological development in infancy and childhood (Wagner et al. 1998). Both animal and human studies have shown that fetal exposure to amphetamines increases the risk of reduced fetal growth, cardiac anomalies, and cleft lip and palate (Winslow et al. 2007). Unfortunately, knowledge of the effects of methamphetamine during pregnancy is limited. While there is evidence of increased rates of premature delivery, placental abruption, reduced fetal growth, and heart abnormalities, studies are confounded by other issues, including polysubstance abuse among participants and methodological issues in the research design. In one study, which took into account several confounding variables, findings suggest that methamphetamine exposure in utero is

associated with decreased growth (including lower birth weight) and smaller gestational age for exposed neonates (Smith et al. 2006).

Tobacco Use and Birth Outcomes

Women who smoke tobacco increase their chances of ectopic pregnancy (development of a fetus outside the uterus), spontaneous abortion, premature rupture of membranes, abruptio placentae, placenta previa, preeclampsia, and preterm delivery. Infants born to women who smoke are more likely to have lower birth weights and have an increased risk of SIDS (Office of the Surgeon General 2001b; Visscher et al. 2003). Children of parents who smoke heavily can be affected adversely in their auditory, language, and cognitive performance; hyperactivity and attention deficit disorders are also common, according to the literature (Bell and Lau 1995). Studies have also drawn an association between maternal smoking during pregnancy and disruptive behavior earlier in development (NIDA 2008; Wakschlag et al. 2006; Wakschlag et al. 2002).

Effects of Alcohol and Illicit Drugs on HIV/AIDS Status

People who inject drugs have a high prevalence of co-infection with tuberculosis, hepatitis, and HIV (Cohn 2002; Martin et al. 2000). Evidence suggests that women who inject drugs often incur added risk by injecting after men, who often procure the drugs and injection equipment (Pugatch et al. 2000). According to CDC (2002), 57 percent of HIV infections among women are attributable to use of injection drugs or intercourse with a person who injects drugs.

Some substances make women more vulnerable to STDs because of physiological changes. For example, women who abuse large amounts of alcohol tend to have drier mucous membranes, which results in abrasions and small tears that allow HIV easier access to the bloodstream during intercourse (Norris and Hughes 1996).

Douching increases vulnerability to HIV by removing protective bacteria (Cottrell 2003; Funkhouser et al. 2002).

Since timely treatment for HIV/AIDS can virtually eliminate the chance of a pregnant woman passing the infection to her fetus, all women with substance use histories should have an HIV/AIDS evaluation at the first sign of any possible pregnancy.

Although highly active antiretroviral therapy (HAART) has extended survival time, evidence suggests that the gains are not equal when comparing gender and status as a person who uses injection drugs. Poundstone and colleagues (2001) concluded that women who inject drugs do not benefit as much as men and women who do not use injectable drugs. CDC (1998) reports that antiretroviral drugs administered to pregnant women and their newborns have been shown to reduce greatly the risk of perinatal mother-to-child HIV/AIDS transmission. Aggressive combinations of drugs currently are recommended, but the specific regimens that can both treat a client's HIV/AIDS infection and reduce perinatal transmission depend on many factors. The ability to provide effective health care to women who are HIV positive can be influenced significantly by their use of substances and adherence to therapy (Lucas et al. 2006). Once women are in treatment, counselors need to ensure that they are provided with or referred for medical and prenatal care as soon as possible to prevent medical complications. For more detailed information regarding HIV/AIDS, refer to *TIP 37 Substance Abuse Treatment for Persons with HIV/AIDS* (CSAT 2000c).

HCV and Women

The hepatitis C virus (HCV) is the primary cause of cirrhosis and liver cancer in United States. An estimated 4.1 million people in the United States are infected with HCV. Of these, 80 to 85 percent will develop chronic hepatitis C, but the rate is lower for women. In 2006, the rate of HCV in women was 0.25 cases per 100,000 (CDC 2008).

HCV can remain silent for many years; most people infected with chronic hepatitis C thus may not be aware that they are infected because they are not chronically ill (Heintges and Wands 1997). For some, the only sign of an infection is found in blood test results. A positive result can occur when the liver enzyme ALT is abnormally high. Women's ALT levels are naturally lower than men's, yet the cutoff number for abnormal liver tests is the same for both sexes. This can result in women being misdiagnosed as having a normal ALT level. If a woman's liver enzymes are on the high side of normal or she has any risk factors for HCV, testing is recommended for HCV (Porter 2008).

Approximately 250,000 women are infected with HCV due to blood they received after a cesarean section prior to 1992 (Porter 2008). Since 1992, screening and regulations on U.S. blood supplies ensure that the recipient is free from risks of contracting any blood-borne illness. Currently, risk factors for contracting HCV are generally the same for men and women, yet women are at higher risk of contracting HCV from sexual contact with an HCV-positive partner, and women are more likely to be initiated into drug use or share equipment for injection drugs with a sexual partner. Below is a list of risk factors for acquiring HCV:

- Injection drug use (56 percent of HCV cases in men and women reported in 2006; CDC 2008).
- Sexual contact with HCV positive partner (0–3 percent for women in monogamous heterosexual relationships; the risk increases with multiple partners, the presence of a sexually transmitted disease, hepatitis B virus [HBV], or open sores, cuts, or wounds [Porter 2008]; 1–12 percent among female prostitutes [The C. Everett Koop Institute 2008]).
- Occupational exposure (1.5 percent of HCV cases reported in 2006; CDC 2008) through the use of razors, needles, nail files, a barber's scissors, tattooing equipment, or body piercing or acupuncture needles if these items are contaminated by blood from an infected person.

- Perinatal or vertical transmission (5 percent in children of mothers with HCV monoinfection; 18.7 percent rate in mothers with HIV/HCV co-infection; Bell et al. 2004).

Almost one out of four newly diagnosed cases of HIV in the United States is a woman, and approximately 20 percent of these newly diagnosed women with HIV are co-infected with HCV (Orenstein and Tsogas 2001). Among pregnant and nonpregnant women, HCV and HIV co-infection is significantly associated with injection drug use (Nikolopoulou et al. 2005). The rate of HIV/HCV co-infection may be as high as 50 to 90 percent for those who contracted HIV through injection drug use. HIV co-infection with HCV appears to raise the risk of mother-to-child transmission to 18.7 percent. The risk for transmission from a woman with HCV monoinfection to her infant is 5.4 percent (Bell et al. 2004).

Prevention and intervention

Prevention strategies are gender neutral and include screening blood, plasma, organ, tissue, and sperm donors; effective infection control practices; identification, testing, and counseling of at-risk persons; and medical management of infected persons (Bell 2004).

Although this is by no means an overview of the disease or its treatment process, a review of interventions can prove beneficial when working with clients who are infected with HCV. Gender-specific guidelines for intervention are minimal.

Early medical intervention is helpful even though people infected with HCV infection often experience mild symptoms and subsequently do not seek treatment. Not everyone with hepatitis C needs medical treatment. Treatment is determined by HCV genotype, viral load, liver enzyme levels, and extent of liver damage. There are many elements to consider when undergoing treatment for chronic hepatitis C virus. Women are slightly more likely to respond favorably to HCV treatment; however, there are gender-specific issues that factor into the decision to start treatment.

Issues of treatment specific to women

- Women should not get pregnant during and up to 6 months following HCV treatment; for those who are in treatment after childbirth, breastfeeding should be avoided.
- Autoimmune conditions occur more often in women than men. One of the HCV medications, interferon, can aggravate autoimmune diseases.
- Women have less hemoglobin (a component of red blood cells that carries oxygen to the cells) than men. Menstruating women have even lower hemoglobin levels because of monthly blood loss, which can sometimes cause anemia. HCV-positive women undergoing treatment should talk to their medical advisor about ribavirin (one of the treatment medications for HCV) and its connection to hemolytic anemia—a type of anemia that causes red blood cells to burst before the body has a chance to use them. Women, especially menstruating women, are vulnerable to this kind of anemia and need to be monitored with regular blood tests during treatment.

In general, women are two times more likely than men to have depression. Depression is a common side effect of HCV treatment medications. Some providers recommend starting an antidepressant prior to starting treatment for HCV (Porter 2005).

Women are less likely to need HCV treatment because they tend to have less severe liver damage due to the virus (Highleyman 2005). Approximately 3 to 20 percent of clients with chronic HCV will develop cirrhosis over a 20- to 30-year period (CDC 1998). Alcoholic beverage consumption accelerates HCV-associated fibrosis and cirrhosis. A study by Chen et al. (2007) reveals that heavy alcohol use affects females more strongly than males, resulting in a higher mortality rate. This difference may be due to the more detrimental effect of alcohol on the progression of liver injury among women than among men with a similar level of alcohol use (Becker et al. 1996). Current guidelines strongly

recommend that HCV patients be vaccinated for hepatitis A and B if they have not yet been exposed to these viruses, as these would radically worsen their liver disease.

Some ways addiction counselors can contribute to treatment are (for review, see Sylvestre 2007):

- Providing education and lifestyle guidelines.
- Distributing information on HCV in substance abuse treatment programs.
- Providing information on intervention programs such as the Healthy Liver Group. The Healthy Liver Group, launched in 2005, is an hour-long intervention comprising a 30-minute group educational session followed by an individualized meeting with the attending registered nurse to discuss laboratory results (Hagedorn et al. 2007).
- Teaching coping skills for side effects to clients undergoing medical therapy.
- Promoting self-care by urging clients to abstain from alcohol, to get vaccinated for hepatitis A and hepatitis B, and to inform themselves of HCV and its risk factors.

- Providing moral support and hope to clients of obtaining the best possible results by maintaining treatment.

Accessing screening and care on behalf of addicted clients with HCV can take persistence. Although the HCV antibody screening test is relatively inexpensive, the HCV viral test is not, but most county medical clinics and hospitals will provide it (Sylvestre 2007). Substance abuse treatment providers are more apt to spot the signs of depression or mania in those patients on medical therapy for HCV. Early detection and stabilization of any psychiatric side effect should not interrupt the progression of treatment. People with a substance use disorder can participate successfully in HCV therapy. For more information, see the planned TIP *Viral Hepatitis and Substance Use Disorders* (CSAT in development j).

Appendix A: Bibliography

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